

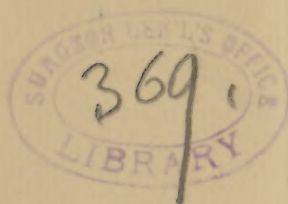
Taylor, (H. L.)

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The Mechanical Treatment of
Senile Coxitis.

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REPRINTED FROM
The New York Medical Journal
for December 15, 1888.



THE MECHANICAL TREATMENT OF SENILE COXITIS.*

By HENRY LING TAYLOR, M. D.

By "senile coxitis" (*malum coxæ senile*) I understand a rheumatoid affection of the hip joint occurring in old people and characterized clinically by local pain, muscular spasm, wasting, stiffness, and disability, but never showing a tendency to suppurate. It may or may not be associated with similar troubles in other joints.

When the hip joint of an elderly person becomes affected in the manner indicated, the cause is usually referred to a dyscrasia with joint manifestations, called rheumatoid arthritis, an affection not confined to the aged and probably having small affinity with tuberculosis, gout, or rheumatism. Its characteristic local lesions are eburnation and atrophy of the bearings of the joint, with hypertrophy and proliferation of its peripheral parts not subject to pressure. Some cases of senile coxitis may have a different causation and morbid anatomy with a similar clinical picture.

The usual treatment is medicinal, dietetic, and local, but many patients go through the various stages of local sensitiveness and disability, sometimes with moderate constitu-

* Read before the American Orthopædic Association at its second annual meeting.



tional reaction, often with long remissions of the active symptoms, until finally the affected joints become crippled and nearly or quite useless. Can anything be done for such of these helpless old people as seem likely to resist or have already resisted orthodox treatment?

It is stated that *malum coxæ senile* sometimes follows directly on local traumatism, and while it must be admitted that some cases of impacted fracture of the neck of the femur may have been confounded with inflammatory trouble in the observations, we can not help noticing the positive effects of traumatism in determining or aggravating attacks.

It would seem on general physiological grounds that the strain and pressure of attempted free locomotion must aggravate the local difficulty, and that an endeavor might reasonably be made to allay irritation and improve the local and general nutrition by efficient mechanical protection to the disabled hip joint. If it is feared that these old people can not or will not submit to mechanical measures, we have not found it so in our experience; indeed, I am able to make the broader statement that adult or advanced life is a much less unfavorable factor in orthopædic practice than is usually supposed. Nevertheless, in devising a plan of treatment for senile coxitis, unnecessary confinement of body and limb has been avoided.

In several cases which had resisted previous treatment, and the patient seemed urgently to need help, we have tried the plan of applying counter-traction thoroughly, and then protecting the joint from all traumatism for a considerable period. The patient is put to bed with the long counter-traction hip splint and extra weight attached, the leg being supported in a sling. At the end of a month or six weeks we find the muscles about the hip joint softer, and position and mobility improved, and allow the patient to go about on the jointed supporting splint ("Dows's"), which pro-

fects the hip joint from pressure, but allows motion at the hip, knee, and ankle. The patient is thus enabled to enjoy the benefit of fresh air and moderate exercise with a certain amount of healthy stimulation to the now quiescent joint, through the protected and pressureless motion. If progress is not satisfactory, the traction in bed is repeated, and the patient again allowed to go about after a few weeks.

CASE I.—Mrs. W., aged fifty-seven years, came in March, 1883, with the history of trouble in the left hip joint of two years' standing, but she stated that she had had some tenderness in several joints for four years. The trouble began in her right shoulder and had affected the elbows, wrists, right ankle, and one finger. The toes never got sore and the fingers were not deformed. She stated that her general health had been good, but she looked delicate and rather older than she was. The tenderness and pain in the joints had never laid her up and she had felt well throughout. About two years before she had stepped into a hole and hurt her foot, and for the past year had limped with the left leg. During the summer of 1882 she began to have difficulty in going up stairs and to feel weak and have pain in the anterior thigh muscles on motion, and stiffness in the left limb. She had noticed soreness in the left groin for two weeks, but had always supposed the pain to be due to muscular rheumatism, and never suspected that the hip was affected until told by her physician two weeks previously.

On examination, tenderness, crepitus, and limited motion were found, to a greater or less extent, in several joints, noticeably in the right elbow and both wrists. The left thigh was considerably flexed and adducted, and there was a coarse crepitus at the hip joint. She was very helpless, walking with difficulty. She was put to bed with long counter-traction splint and eighteen pounds extra weight for six weeks, and then allowed to go about on crutches, with a jointed supporting splint ("Dows's"), which took the weight off the joint.

The condition of the hip improved slowly, but perceptibly, from the start. Soreness became less, and position and motion at the hip improved. In the winter of 1884-'85 she was walk-

ing readily around the house without crutches. The following summer (1885) she went to Richfield Springs, and took the apparatus off to take the baths; she found she could walk so well that she did not put it on again. When I saw her in November, 1885, she walked very nicely, and had extensive motion at the hip in all directions, with very little tenderness. The condition of the other joints seemed no better; crepitus, stiffness, and tenderness were about the same as before. In a letter just received, her daughter writes, in answer to my inquiry; "We think mother quite as active as any member of the family; a little lame, but so much better than we ever expected to see her, [we] do not notice the limp. . . . She is very comfortable, as far as the rheumatism will allow; her hands are quite weak and somewhat out of shape."

CASE II.—Mrs. R., aged fifty-eight, came in February, 1883. She was a large, strong, young-looking woman, had always had excellent health, and her family history was good. Eight years previous to coming the patient noticed that the right foot was rotated out; when she turned it in, it caused pain on the inside of the knee; this pain also came when she got fatigued. It gradually grew worse, and for the past four or five years she had given up one duty after another, owing to lameness and increased pain. She had always supposed the knee to be at fault, and neither she nor her doctor had ever suspected the hip. For two years past she had been obliged to put a pillow under the right knee in order to be able to sleep, and the knee had received electrical and other treatment.

Examination showed the right thigh considerably flexed and adducted. Mobility at the hip was almost gone, except flexion and extension through a few degrees. She never had pain except when tired—then it came on the outer aspect of the right knee; when she was still more tired, in anterior part of thigh, hip, and back. She had a moderate lameness. The functions of the knee were normal.

The patient was put to bed, with the long hip splint, sixteen pounds extra weight, and sling, for a month, during which time the thigh muscles relaxed, flexion was reduced, and pain was latterly absent. She was then allowed to get up on the jointed

supporting splint ("Dows's"), and in a few days was walking nicely with the apparatus only, and feeling no pain.

The patient did well, but had on a few occasions some recurrence of pain, and once or twice was put to bed for two weeks with counter-traction as before. In January, 1885, the apparatus was removed, and she was discharged cured, walking easily, with but slight limp; position of limb almost normal, mobility increased. When last seen, over a year after her discharge, she got around very readily and comfortably, having retained what she had gained.

These results have been sufficiently encouraging to warrant the belief that many cases of intractable senile coxitis may be much relieved and an unserviceable limb restored to comfortable use by a plan of treatment such as the one described.

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